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**Testimony of Victoria Veltri
General Counsel**

**Before the Insurance and Real Estate Committee
In support of HB 5303, SB 258 and SB 260
March 4, 2010**

Good morning, Senator Crisco, Representative Fontana, Senator Caligiuri, Representative D'Amelio and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, General Counsel with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

OHA supports HB 5303, AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA. These reporting requirements are necessary to provide a fuller picture of the number of all types of denials. This is critical to gauging the rate of all denials by the insurers. The inclusion of this information on the consumer report card and on the Insurance Department's website is an important move toward optimal transparency. Capturing all denials provides a truer picture of the marketplace.

OHA offers two suggestions that we think are necessary for the bill to achieve its goal:

- A. While it is clear in the Insurance Department's requests to insurers for report card data, the bill would be clearer if it included a definition for "denial" or referenced the fact that denials include "partial denials". It must be clear that every instance of the word "denial" in the bill is meant to include "partial denials."
- B. Although section 1(a)(6)(E) states that the types of denials to be reported are not limited to those listed, the committee could improve this subsection by including "experimental and/or investigational" as one of the denial types required.

OHA also supports SB 258, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS. This bill contains provisions consistent with our recent proposals that provide deference to a provider's medical judgment. No reviewer in a utilization review company can ever step completely into the shoes of a provider in the application of medical judgment in a specific case. Every year, the utilization review companies, many of whom are subsidiaries of the insurers themselves, are making medical determinations. In our experience, the insurers are going beyond medical necessity coverage determinations to substitute their medical judgment for that of the providers. This happens in surgical cases and behavioral health cases more and more frequently. An insurer may determine that a service is not medically necessary, but it is not the insurer's role to practice medicine on a patient they have never examined – suggesting an alternative, lower-level of care or a different kind of surgery, for example. While the insurers might argue that the decisions they are making are merely coverage determinations, more often than not, they are de facto denials of services or treatment. In most cases, consumers cannot afford to go ahead with a medical treatment that has been denied.

The insurers will undoubtedly testify that to provide a presumption of medical necessity for a provider's judgment will destroy managed care. We reject that notion. Insurers can still subject a service to prior authorization or post-service utilization review. The only change this bill makes is to shift the burden to where it properly belongs, onto the insurers. It is not unheard of for provider's decisions to be accorded deference. Such deference exists in Medicaid and in Social Security for disability determinations. We've witnessed a significant level of second guessing of providers; MCO peer reviews that are not based on a complete record; and, arbitrary limitations made on approved services. We need to restore deference to the providers who actually examine and treat the patient.

OHA supports the provisions of SB 258 requiring the utilization review company to furnish a provider and an enrollee with the information the company used to make its determination. This information is crucial for the preparation of an appeal.

OHA also supports SB 260, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS. The limitation of coverage for routine patient care costs to clinical trials for cancer is not allowable under Connecticut law. However, there are treatments for other disabling, progressive or life-threatening medical conditions that also undergo clinical trials. With rapidly advancing medical technology, it's likely that clinical trials for the treatment of illnesses other than cancer will be available to those who cannot succeed on approved treatments. The bill appropriately limits coverage of routine patient care costs to individuals with disabling, progressive, or life-threatening medical conditions. This is a fair and overdue extension of our current statutory scheme.

Thank you for allowing me to testify today. If you have any questions, you may contact me at victoria.veltri@ct.gov or 860-297-3982.